

Commonwealth of Massachusetts

## **MassHealth Drug Utilization Review Program**

P.O. Box 2586

Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## **Statin Prior Authorization Request**

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for quantities greater than 30 units per month for all statins. In addition to the quantity limits, PA is required for Advicor, Altocor, Mevacor, Pravachol, and Zocor. PA will not be required for quantities less than or equal to 30 units per month for Crestor, Lescol, Lescol XL, Lipitor, or generic lovastatin. Additional information about statins can be found within the MassHealth Drug List at www.mass.gov/masshealth.

## **Member information**

Last name	First name	9	MI	MassHealth member ID r	10.	Date of birth	Sex (Cir	cle one.)
Member's place of residence	e home	nursing facility						
Medication infor	mation							
Please complete if the requirements greater than 30 u		Dose, frequency, and durat	ion of	requested drug	Drug	or service code	,	
Statin request Qua	ntity per month	Indication for statin reques	sted (C	heck one or all that apply.)	)			
☐ Advicor		☐ Hypertriglyceridemia	•	Primary hype	erchole	esterolemia		
☐ Altocor		☐ Mixed dyslipidemia		☐ Secondary p	revent	tion of cardiovas	cular eve	ent
☐ Crestor		Other. Specify pertinent	medica	l history, diagnostic studies	, and/	or laboratory re	sults.	
Lescol								
☐ Lescol XL								
Lipitor								
□ lovastatin								
☐ Mevacor (brand name)								
☐ Pravachol								
□ Zocor								
Section   Please complet	te Section Lif vour real	uest is for more than 30 units	s ner m	nonth				
i iodos compios		ntity and frequency, including			fv per	tinent medical h	nistory	
diagnostic studies and/or la			- G-		. , po.			
	dose consolidation? (e.g	g., member is on Lipitor 10 m	ng BID,	and dose can be consolida	ated to	o Lipitor 20 mg	QD, <b>wh</b> i	ich
Please provide rationale for	a regimen of greater	than one unit per day						

PA-9 (Rev. 04/04) over >

## **Medication information** (cont.)

Has member tried two of the following statins: Crestor, LescoVLescot X, Lipitor, or generic lovastatin?    Statins: Crestor, LescoVLescot X, Lipitor, or generic lovastatin?   Statins: Version   Dates of use   Dose and frequency	Section II Please complete Section II i	A	Drug name	or (brand name), Pravacnoi, or 2	.OCOI.					
Dates of use Dose and frequency    Yes. Complete boxes A and B.		or,								
No. Explain why not.		Dat	tes of use	Dose and fre	equency					
Adverse reaction	Yes. Complete boxes A and B.	Did	member experience any of t	he following?						
Briefly describe details of adverse reaction, inadequate response, or other.    B. Drug name   Dates of use   Dose and frequency   Did member experience any of the following?   Adverse reaction   Inadequate response   Other   Briefly describe details of adverse reaction, inadequate response, or other.    Note: You may be asked to provide supporting documentation (e.g., copies of medical recoffice notes, and/or completed FDA MedWatch form).    Note: You may be asked to provide supporting documentation (e.g., copies of medical recoffice notes, and/or completed FDA MedWatch form).    Note: You may be asked to provide supporting documentation (e.g., copies of medical recoffice notes, and/or completed FDA MedWatch form).    Note: You may be asked to provide supporting documentation (e.g., copies of medical recoffice notes, and/or completed FDA MedWatch form).    Note: You may be asked to provide supporting documentation (e.g., copies of medical recoffice notes, and/or completed FDA MedWatch form).    Image: Planta	☐ No. Explain why not.									
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